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OPHTHALMIC REACTION TO TRYPARSAMIDE IN THE TREATMENT OF NEUROSYPHILIS

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In January, 1934, I was relieved from routine duties as ophthalmologist at the Charles V. Chapin Hospital to take charge of the examinations of the cases of neuro-syphilis. This seemed necessary due to the fact that, although the treatment of these patients by tryparsamide produced most favorable results, there was ever present the fear of impairment of vision from the special affinity of this drug for the optic tracts. Are there any indications to be found by examination of the eyes that would cause one to suspect such a reaction? A survey of the literature on this subject still leaves one in a quandary.

Behr lists four counter-indications to its use: 1. Diminished central vision, loss of color fields with normal or almost normal form fields. 2. A high degree of concentric contraction of form and color fields with central vision normal. 3. Transient visual disturbances, more in form than color, although central vision is good. 4. Subjective complaint of photopsia. Our examinations have shown that if the above rules are applied, practically all of the cases that are most urgently in need of this drug would be denied its benefit. Lillie has pointed out that it is the failure to take visual fields and a lack of previous knowledge of the various changes that have been going on in the eye that has lead many to attribute all ocular symptoms after its administration to be directly caused by tryparsamide. Too frequently it is but the continuation of pathological processes already far advanced. Fouche has stated that the optic atrophy of tabes or general paresis is always progressive and although its advance to complete blindness is slow, it is always sure. In the face of these and many other conflicting views, it was our task to try to establish some kind of practical working rule for the handling of these cases. I regret that although we have been over three years, the solution is not yet at hand although we have had many interesting subjects to study. However, certain trends of thought have been established.

Our system consisted in first examining the eyes as to motility, pupilary reflexes, media and fundus, then the central visual acuity with and without glasses, lastly the form and color fields. If possible all this was done before fever therapy and again preceding the administration of tryparsamide. If the patient was non-cooperative the examination was as extensive as could be and later attempts to finish the records were made as the patient improved. During the period of the first ten treatments, special care was taken to note any changes in the eyes. If there were none they were given the routine examination every six months. In all, one hundred cases of neurosyphilis were examined, of whom forty received tryparsamide.

All cases having a plus Wassermann spinal fluid, with one exception, had contracted color fields within recognized pathological limits. The one case which was lacking in this particular was also negative to all signs and tests of brain syphilis. Was it possible that the spinal cord was affected prior to any changes in the higher centres? So consistent was this situation found to be that even the cases which had long since been made spinal negative by treatment still retained the contracted color fields. A few cases which showed improvement of their color fields under treatment never went entirely back to normal. As a number of cases with blood plus Wassermann and spinal negative showed contracted color fields the question arises whether they are not potential cases of neuro-syphilis. This lead me to make the assertion, in 1934, that the presence of a contracted color field in a blood syphilis case which condition can not be accounted for by any other cause, is a presumptive sign that the brain is

Read before the Providence Medical Association at the meeting on June 7, 1937.

becoming involved.* It is surprising to learn how many cases of neuro-syphilis show no other ocular sign. Next in frequency is the so-called Argyle-Robertson pupil, appearing in one or both eyes. A number having apparently normal fundi presented contracted form fields to a slight degree. This was almost always a small border segment in the upper, outer, temporal quadrant in one or both eyes, which loss, was sometimes regained during treatment. Unless there was some visible lesion in the retina, choroid or nerve, there was no diminution in central visual acuity.

Out of our series of 40 cases having tryparsamide, five had their eyes affected during treatment. A sixth was picked up on routine six months' examination which showed changes that could not be attributed to any other cause. This raises our percentage of eye reactions to 15. Five of these cases had, prior to reaction, good central vision, normal form fields and nothing on ophthalmoscopic examination that would indicate any disease of the tissues viewed. On the other hand patients with old iridic adhesions, retinitis of arterio-sclerotic origin and even tabetic atrophy were thus treated, without harm. In fact I am sure that in some of these the progress of the disease has been arrested. The one disastrous result was in a patient having a syphilitic retino-choroiditis with greatly contracted form fields. Here there seemed to be a definite counter indication; yet another case, blind in one eye and fast losing the other, has been held in check up to the present time. Five of the group had Argyle-Robertson pupils but one reacted to light and accommodation.

The symptoms produced by tryparsamide shock reaction are intensely subjective. The patients complain of colors, dust or fog before the eyes. There is a marked nervous condition with a feeling of uncertainty in going about. Frequently on examination, the central visual acuity is found to be normal or at least the same as it had been for a long time prior to the complaint.

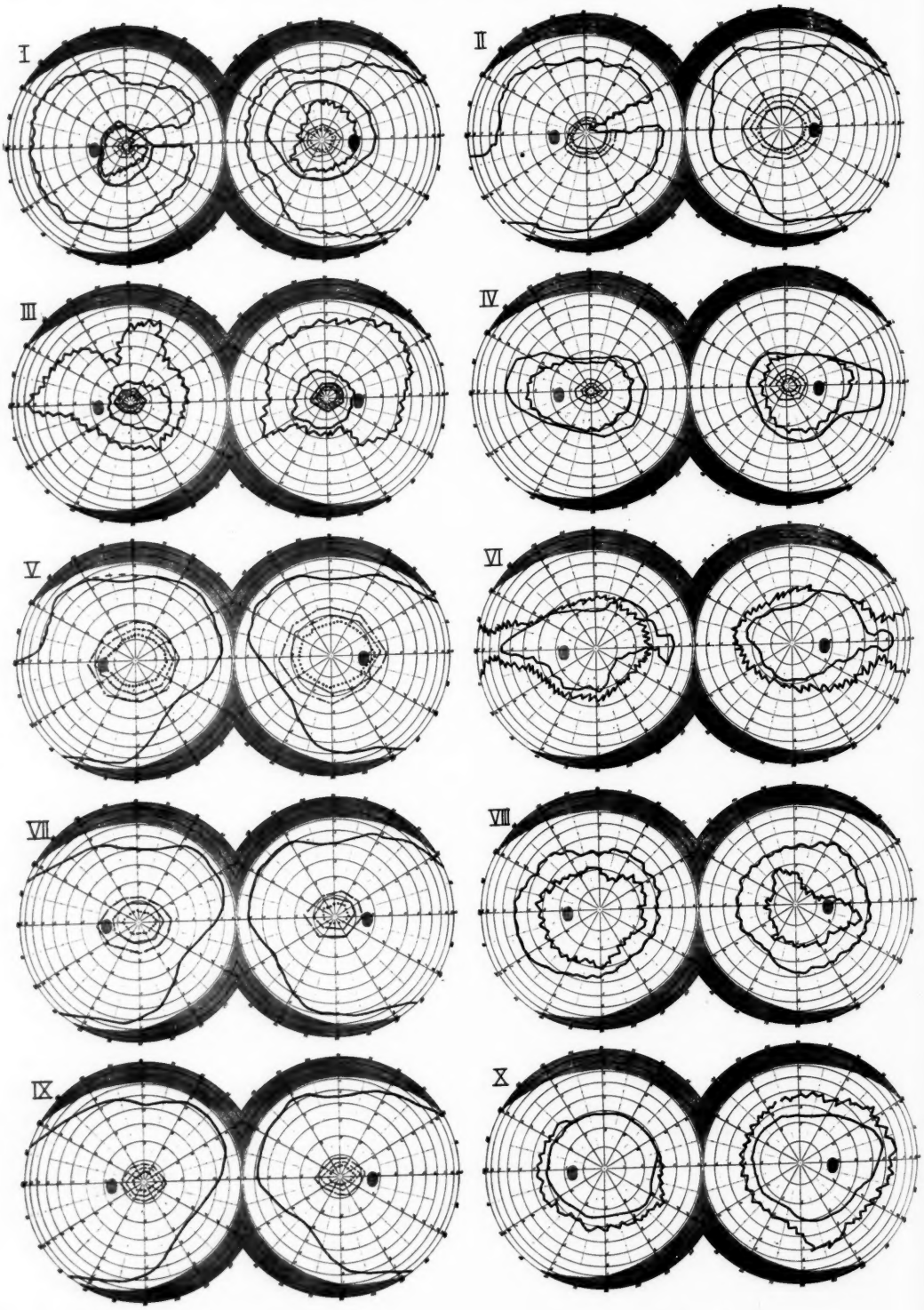
As far as the media and eye grounds were concerned, there was nothing different from that found on previous examinations. In the histories which follow I have quoted other members of the staff whose examinations verify this point although it seems to be in opposition to some observers. On taking the form fields one discovers a marked contraction in comparison with that of the previous records. This, if the examination is early, generally continues for a few days when slowly an improvement is noticed. This improvement continues until a final stationary point is reached but never fully back to the previous state. I have never seen the color field further contracted from its original position unless the form field was so choked down that it reached the color territory when it, as well as the perception of form, was lost; and again central visual acuity seems to be little touched unless the contraction of the form field encroaches upon the fovia centralis, when all may be lost. Some severe reactions allow 20/20 or even 20/15 vision.

We agree with other observers that the reaction is apt to come during the first ten doses. Two of our worst were after the second dose while the next most severe followed the fifth. The two least affected were after 8 and 16 treatments respectively.

Therefore we are forced to conclude that there are no indications by which one might expect to obtain an ophthalmic reaction from the use of tryparsamide. The most that one can say is that there seems to be an individual idiosyncrasy or allergic susceptibility to this drug in certain individuals. If one does get a reaction in the presence of an already contracted form field grave results are to be expected. However, the presence of such a contracted field is no evidence *per se* that bad results are to follow this treatment. Such deductions as above made on so small a number of cases over but a three year period cannot be conclusive but rather point the way for further studies.

The excellent results obtained in treating neuro-syphilis in the early stages by fever therapy followed bytryparsamide should stimulate further endeavor to obtain frequent spinal fluid analysis in all cases of blood syphilis. May I raise the question whether, in the presence of a positive blood and a negative spinal fluid and a contracted color field, the patient might be considered a potential neuro-syphilis case? Further, after a careful survey of the history, would not fever therapy followed by tryparsamide place this treatment in the field of preventive medicine, thereby reducing the dreaded brain syphilis to a minimum? It is at least demonstrated that a much closer cooperation between the ophthalmologist and the syphilologist must be established if these cases are to receive proper care and especially is this true if an early diagnosis of neuro-syphilis is to be made

*Muncy, William M.: Contraction of the Color Fields in Neurosyphilis, R. I. Medical Journal, XVIII, p. 9. January, 1935.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or tryparsamide, the most beneficial drug for its treatment, is to be administered. I will now briefly review the 6 cases which reacted adversely to tryparsamide, they being the major source of the material for this paper.

Case I.

Mr. E. S., age 52; diagnosis, tabes.

Dr. Messenger's examination of the eyes on November 14, 1934, was as follows: "pupils are small, left being larger than the right. They react to accommodation but not to light. Findings are otherwise normal." This patient was given a course of therapeutic malaria followed by two doses of tryparsamide, 3 grams each. Complaining of failing vision and spots before his eyes, he was sent to me for examination on January 2, 1935. I found the pupils did not react to light, the media clear, fundus apparently normal with a vision with glass correction of 20/30 in each eye. Fields were found to be as in Chart 1, straight line. Examinations were made almost daily as the fields became smaller until the 9th, (see Chart 1, zigzag line), from which time they continued to improve until August 27, 1935 (see Chart 1, waved line). On September 25, 1935, tryparsamide was resumed. There was no reaction noticed although for a long time frequent examinations were made. He has had since then to date 52 doses of 3 grams each. The patient is in excellent health, working every day. Chart 2, made May 18, 1937, will not only show the present state of his form fields but also enlarged color fields.* The visual acuity was normal in the right and 20/30 in the left eye.

Case II.

Mr. M. S., age 37; diagnosis, general paresis.

After admission he had therapeutic malaria. Dr. Hacking's examination was as follows: "pupils equal, do not react to light direct or consensually but react to accommodation. Lens and media clear. Disc outlines clear and well defined. Arteries and veins within normal limits. Retina shows no hemorrhages or exudates." My examination on May 3, 1934, was similar. The vision was found to be ½ of the 20/20 line in the right eye and 20/20 in the left eye. Form fields were normal but markedly contracted color fields were present. After 5 doses of 3 grams of tryparsamide he complained of poor vision and ran into objects when going about (tubular vision). Dr. Hacking's examination at this time, June 13, could find no objective evidence of any eye pathology. Making my examination on the 16th, I could find no vision defect in the media or retina. The central visual acuity was the same as when first examined but the form fields had contracted down to the original color fields, which in themselves were not changed (see Chart 3, straight line). The patient refused to stay at the hospital although his form fields had tripled in size by the 20th of June, the date of his departure (see Chart 3, waved line). However on June 4, 1935, a year later, I induced him to come to my office where the last examination was made. Vision was then 20/20 in both eyes. Although the color fields were still the same as originally, the form fields were so enlarged that he drives an automobile at his occupation as salesman for a motor oil company (see Chart 3, zigzag line).

Case III.

Mr. H. M., age 36; diagnosis, tabo-paresis.

Was transferred to the house May 29, 1936, and I examined him on the 9th of June. His pupils were unequal, the right being larger than the left. They did not react to light but reacted to accommodation. The lens and media were clear. Vessels appeared attenuated with discs pale, especially on the temporal side. The right eye had many small, discrete, yellowish-white exudates scattered throughout the fundus, especially in the periphery. The left eye showed a few of the same exudates in the outer temporal side. The vision was 20/20 which with a slight glass correction could be brought to 20/15. He was given typhoid antibodies treatment, followed by two doses of tryparsamide, when he complained of visual disturbances. His form field prior to treatment was as Chart 4, straight line, but his examination at this time, June 23, showed further contraction to Chart 4, zigzag line. His central acuity was still 20/15. His vision continued to fail and on August 10, 1936, he was admitted to the State Infirmary, having become blind. The fact that this was a case of syphilitic retino-choroiditis may have had some relationship to the result. We have given tryparsamide to other cases of retinitis and choroiditis without harmful results, in fact one case with a blind left eye and a rapid progression in the right eye, which had contracted down to 20° with a visual acuity of 3/200, has apparently been kept stationary under tryparsamide treatment. The rule still holds, nevertheless, that if fields already markedly contracted are further encroached upon, severe lasting damage must be expected.

* Dot and dash line blue, dash line red, dotted line green.

Case IV.

Mr. C. K., age 51; diagnosis, general paresis.

First examination was made June 2, 1936, when vision, with glass correction, was found to be 20/20. Left pupil smaller than the right, does not react to light but reacts to accommodation. The color fields are very large for a neuro-syphilis case, although still pathological. The form fields are within normal limits but there is a conspicuous contraction in the upper temporal quadrant of the left eye. This contraction was the same for various sized test objects (see Chart 5). On August 11, after eight tryparsamide treatments of 3 grams each, he suddenly complained of poor vision and uncertainty in getting about. His central vision was found to be the same as above but his form fields were much contracted (see Chart 6, straight line). The visual fields continued to enlarge slowly until they had extended along the median line temporally on each side, thus improving materially his ability in walking (see Chart 6, zigzag line). On February 2, 1937, he was given one gram of tryparsamide for three doses when three gram treatments were resumed. Up to May 18, 1937, he has had nine of these without any untoward results.

Case V.

Mr. A. F., age 51; diagnosis, tabo-paresis.

No fever therapy was given on admission because of his poor health. On examination, October 6, 1936, vision in the right eye without glass correction was 20/30 and in the left eye, ½ of the 20/20 line. Pupils were small, even, but did not react to light. Normal reaction to accommodation. The form fields were normal with color fields contracted down to between 15° and 10° (see Chart 7). After 16 treatments with tryparsamide he complained of specks before the eyes. On December 12, 1936, he showed an acuity of vision of ½ of the 20/30 line but with contraction of the form fields in both eyes. This continued until the greatest damage was recorded on February 5, 1937 (see Chart 8, zigzag line). He was readmitted to the hospital January 5, 1937, under the diagnosis of general paresis, and fever therapy was administered. Eye examination by Dr. Grossman, "Pupils small and rigid to light, react to accommodation. Argyle-Robertson discs pale, fundus otherwise normal." April 18, 1937, I find the above correct with a vision of 20/30 in the right and 20/20 in the left eye and a considerable enlargement of the form fields (see Chart 8, waved line).

Case VI.

Mr. A. C., age 53; diagnosis, general paresis.

Was first examined May 28, 1934. Vision with correcting glasses of 20/20, pupils reacted to light and accommodation, media was clear and disc well defined and normal, nothing abnormal in the retina. Form fields were found to be normal but with color fields contracted to 10° and less (see Chart 9). Therapeutic malaria was given followed by tryparsamide in August, 1936, ending a series of 70 treatments. Routine examination, November 17, 1936, showed marked contraction of the form fields which continued to January 12, 1937 (see Chart 10, straight line), when it became stationary and improved later to May 18, 1937 (see Chart 10, zigzag line) with vision still 20/20. The media and the retina appeared normal. In view of the findings and the similarity of this case to those previously reported I can attribute the condition to no other cause than a reaction to tryparsamide. Either the visual changes failed to produce subjective symptoms sufficient to cause the patient to complain or, what is more likely to be the case, his inability to speak English readily, combined with phlegmatic disposition, let the effect of the contracted field pass unmentioned.

THE MODERN TREATMENT OF NEUROSYPHILIS

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There have been 162 cases of neurosyphilis admitted to the psychiatric wards of the Charles V. Chapin Hospital from June 1, 1930 to January 1, 1937. Of this number, sixty-five or 41% are definitely improved and able to adapt themselves outside an institution; forty patients or 24% have not improved sufficiently to adjust in the community; and fifty-seven or 35% have died since their first admission to the psychiatric wards. This survey comprises all types of neurosyphilis admitted—cases of paresis, tabes, tabo-paresis, and cerebral lues; it includes far advanced demented patients and those whose general physical status was extremely poor; it takes into consideration both treated and untreated cases.

Going back a relatively few years, before modern treatment of neurosyphilis was instituted the mor-

tality was practically 100%. Now it is reliably stated that almost 100% can be cured. The following tabulation shows continuous improvement in the results of treatment:

	Total	Unimproved		Improved		Dead	
	No.	No.	%	No.	%	No.	%
1930	9	4	44⅔	2	22	3	33⅓
1931	18	8	45	2	11	8	44
1932	32	6	20	14	42	12	38
1933	37	9	26	12	30	16	44
1934	15	3	20	9	60	3	20
1935	26	8	32	8	30	10	38
1936	25	2	8	18	70	5	22

These figures will not tell the whole story as some of the later cases will show a change in status, some will die and others may eventually require institutional care. It is believed, however, that as the medical profession continues to make earlier diagnoses, treatment can be begun sooner and the percentage of discharged patients will therefore be higher.

Because of its severity, it has been difficult to administer adequate treatment in some cases. There are those who are not strong enough physically to tolerate the high fever necessary. Certain eye findings, also, contraindicate the use of tryparsamide, the drug of choice following fever therapy. Of those patients in our series having adequate fever treatment of eight or more elevations in temperature above 103° Fahrenheit, twenty-four or 60% were of the unimproved group; twenty-two or about 40% of the group died; and fifty-one or about 77% improved. At least twelve weekly injections of tryparsamide have been given to twenty-two patients comprising 55% of the unimproved group, fifty-seven or 87% of the improved group, and three cases or 5% of the group that died.

There have been difficulties in making this review complete as patients who show improvement tend to neglect their treatment and can not be followed. At present, with a full-time social worker in the Neuropsychiatric Out-Patient Clinic, follow-up in all cases is possible.

Treatment used on the psychiatric wards of the Charles V. Chapin Hospital consists of induced fever. In the first method the patient is inoculated with tertian malaria and allowed to have as many paroxysms of fever as his physical condition permits. The malaria is given either intravenously or intramuscularly and the time required for this part of the treatment is from four to six weeks. Before inoculation, the patient must have a complete physical study and during the fever he requires careful medical observation. Usually it is easy to terminate the malaria by giving quinine. Malarial therapy has been proved satisfactory wherever it has been in use. There are certain disadvantages; namely, the patient is given a disease; the malaria is toxic and can not be given to debilitated patients; and chronic malaria may follow the treatment course.

The second method, which has been introduced by Dr. Marque O. Nelson of Tulsa, Oklahoma, substitutes typhoid vaccine injections for malaria, in order to produce the desired fever. His procedure consists in giving divided doses of the vaccine to produce a febrile reaction of 103° Fahrenheit or better. To begin the treatment, 25,000,000 dead typhoid bacilli are given intravenously and the patient's temperature, preferably rectal, is taken every half-hour until a rise is noted. Then the temperature is taken every fifteen minutes until it again becomes normal. This first injection is a test reaction and often gives a fever of 103° Fahrenheit without the need for a second injection. On the second day of treatment, the amount of vaccine is doubled and the temperature again recorded. On the third day it is advisable to give an initial dose of 25,000,000 bacilli intravenously and follow this in one and a half hours with 50,000,000. As the treatment progresses, the dose is gradually increased from day to day by approximately 25,000,000 so that on the fourth day of treatment the initial injection is 50,000,000 and the second injection 100,000,000, or double the first. As long as the febrile reaction is well above 103° it is unnecessary to increase the dosage. There is a wide margin of safety in this method of treatment and doses of 500,000,000 and 1,000,000,000 have been given without harmful effects. After ten to fifteen febrile reactions above 103° have been given, the treatment is stopped. At the Chapin Hospital we have used typhoid vaccine with twenty-one patients. Of these, fifteen are now improved, five have died since the treatment and one is unimproved. This series is not large enough to allow conclusions.

Whether typhoid vaccine or malaria is used to produce the fever, careful nursing care is extremely important. Prevention of constipation by means of enemas and forcing fluids to at least 125 to 200 ounces daily, is of primary concern. Between paroxysms of fever the non-debilitated patient may be up

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Read before the Providence Medical Association at the meeting on June 7, 1937.

Hugh E. Kiene, M.D.; Physician in charge of the Psychopathic Department of the Charles V. Chapin Hospital.

and about. Tryparsamide is the preferred drug in the follow-up treatment but is given only after careful examination of the eyes. After the approval of the oculist, tryparsamide is given in doses of 3 grams once a week. The number of treatments depends not only on the patient's symptoms, but also on the spinal fluid serology (Wassermann, cell count, Pandy and gold curve), which must become entirely negative before a cure is effected. There are many other methods of producing fever, including diathermy, radiothermy and a new air-conditioned hot box.

In all cases of syphilis admitted to the psychiatric wards of the Chapin Hospital, members of the patient's family are given routine blood Wassermann examinations. If the blood Wassermann is found positive, a spinal fluid examination is recommended. In this way, several latent cases of neurosyphilis have been discovered and treated, in the husbands or wives of our patients. This indicates that certain strains of the spirocheta pallida may have a predilection for the central nervous system.

To cite examples of fever therapy and the importance of early treatment—a seven-months-old female child was brought to the hospital with the following complaints — a nasal discharge, dry cough, five loose greenish stools a day, frequent vomiting after her bottle, irritability and crying almost continuously. The admission diagnosis was meningitis. Examination of the spinal fluid at the hospital disclosed a strongly positive spinal fluid Wassermann and a high spinal fluid cell count, indicating an active luetic meningitis. For this the child was given typhoid vaccine into the longitudinal sinus, ran a satisfactory febrile course and showed a rapid clearing of the acute symptoms. Examination of the spinal fluid several months later found it practically negative and the child has been in good health since.

The second patient is a man thirty-eight years old, who had a chancre in 1934 and was treated with neosalvarsan and mercuric salicylate. In 1936, after considerable treatment, his blood Wassermann was found doubtful. A spinal fluid examination was done at this time and revealed a Wassermann ++++ with both acetone and cholesterol. He was treated with fever and later with tryparsamide. On April 21, 1937, his spinal fluid Wassermann was doubtful and the other spinal fluid findings greatly improved. In this case, the patient was given adequate treatment for systemic syphilis. When the spinal fluid Wassermann was found positive he was given treatment for neurosyphilis, consisting of fever and tryparsamide. The treatment was instituted before mental symptoms developed. The spinal fluid has shown a marked improvement following the treatment and now, in less than a year, is practically negative. It is interesting to observe in this patient that the invasion of the central nervous system by the spirochete occurred less than two years after the primary lesion.

The third patient also was a man thirty-eight years old, who had his chancre at the age of twenty at which time he consulted a physician and was given arsenicals and bismuth. The exact quantity is not known but the amount given may be judged by the expense of the treatment to the patient, which totaled $400.00. His physician made repeated blood Wassermann tests which were all found negative, so he discharged the patient as cured. In 1933, many years after he had been discharged as cured, the patient wished to marry and wanted a clean bill of health. He consulted his physician and was advised that it would be perfectly all right to be married. Three years after his marriage a change was noticed in his behavior. His wife stated that she observed his judgment was impaired when driving his car; he seemed to lose strength in his hands and dropped things; he was unusually cheerful at his work, singing and humming; he rambled when talking; he refused to associate with people and he said he had made 33 billions through stock, colored pictures and by working. It is needless to say that on admission to the hospital he was found to have neurosyphilis. Typhoid vaccine was given as previously outlined. His response to this was remarkable and after nine weeks in the hospital, he was able to return to his former employment.

After observing neurosyphilis and its effects, one is impressed by the number of cases which have not been treated early enough. Treatment has been proved efficacious and curative. In order to achieve the best results, treatment must be undertaken before the spirochete has caused extensive damage to the brain and spinal cord. Once destroyed, the neurons of the central nervous system do not regenerate so that a cure in the advanced case of neurosyphilis merely results in eliminating syphilis from the body and not in restoring the individual's mental and intellectual ability. For this reason, treatment of primary and secondary syphilis is important. The drugs of choice, in a general way, consist of

arsenic and bismuth preparations given intravenously and intramuscularly. Treatment is concerned with eliminating the patient's symptoms and in clearing up the blood serology.

From the standpoint of prevention of neurosyphilis, the physician should not be satisfied with clearing the patient's symptoms and finding a negative blood report. Every case in which a diagnosis of primary or secondary syphilis has been made, should have a careful neurological examination, mental status and spinal fluid determination before the patient is discharged as no longer in need of treatment. Every physician possesses the necessary knowledge to make such examinations. There is no need to mention the neurological methods; they are familiar to all physicians. Similarly, the mental status is not difficult to determine. It is important to seek indications of mental or personality changes; that is, to determine whether the patient has become irritable, antisocial, extravagant, demanding or forgetful. Convulsions may occur early in neurosyphilis. The wife, husband or someone close to the patient, if carefully questioned, can often tell of early personality changes. Grandiose ideas, as described in text-books, are not always an early symptom. These beliefs of great wealth or strength are often associated with more violent symptoms which necessitate treatment in a psychiatric hospital. With an early diagnosis of neurosyphilis, the physician is able to treat his patient in a general hospital or even in the patient's home.

In closing, I should like to point out that the treatment of neurosyphilis is highly satisfactory; that the earlier a diagnosis is made, the better may be the results effected from the treatment; that typhoid vaccine is a safe method for producting the required fever when given in divided doses; that the central nervous system may be invaded by the spirochete during the primary or secondary stage of the disease; that certain strains of the spirochete seem to have a predilection for the central nervous system; and lastly, that the physician in practice is able to treat satisfactorily early cases of neurosyphilis without the need of admission to a psychiatric hospital.

PUBLIC WARNED

Physicians should warn the public against the devices practiced and the false pretensions made by charlatans which may cause injury to health and loss of life.

From the Code of Ethics of the A. M. A.

SIMPLIFIED OFFICE PHOTOGRAPHY

Dr. F. Ronchese, Providence, R. I.

The dermatologist feels more than any other specialist the need for having good photographic records of his patients. The ordinary procedure of taking a photograph is long and tiresome for both the patient and the physician.

Often it is even embarrassing when the physician covers the role of a professional photographer. The apparatus commonly used for clinical photography is bulky, requires a lot of space, always difficult to find in the average office, and is expensive. To overcome technical and financial difficulties, Ronchese thought of using a flash synchronizer of the type used by newspaper camera men, mounted on a fairly good camera with double bellows extension for close ups.

Three previously fixed distances, sufficient for the need of routine photography, eliminate any further use of the ground glass and the long and tiresome procedure of focusing the subject. The camera is laid down on a table or on any flat mean of support at a previously fixed distance from the subject. The light is given by a small-sized photoflash bulb. The diaphragm is set at 1:16, the speed at 1/25th of a second. The distance measuring stick is withdrawn, the button which lights the bulb and at the same time opens the shutter is pressed, and the photograph is taken. Owing to the speed it becomes very easy to take a picture of a restless patient.

This procedure being quick, done by the physician himself, not very expensive (25c per photograph), and satisfactory, should make more popular routine office photography and increase considerably the percent of good medical illustrations.

Archives of Dermatology and Syphilology, 36:344, August, 1937.

INFRA-RED PHOTOGRAPHY IN THE DIAGNOSIS OF VASCULAR TUMORS

Dr. F. Ronchese, Providence, R. I.

Ronchese shows with many illustrations how infra-red photography helps in the diagnosis of vascular skin tumors when the presence of blood is doubtful.

American Journal of Surgery, 37:475, September, 1937

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OXYGEN THERAPY

In the last decade treatment by inhalation of oxygen has passed from the status of a futile gesture applied to the moribund patient for the comfort of a grieving family to that of a scientific rather exact therapeutic measure which at times may be life saving. Its greatest value as it is applied at present appears to be in the treatment of pneumonia and of certain cardiac conditions in which, as an accessory measure, it may carry the patient through a critical phase of his illness and make recovery possible. What is actually accomplished by the treatment is the overcoming of a state of anoxia or anoxaemia, a condition in which there is an actual deficiency of oxyhemoglobin in the circulating blood and which may result in damage to vital organs, especially the brain and the heart muscle. In coronary artery occlusion, the judicious use of oxygen has enabled many a patient to survive until the heart recovers from the initial shock. In the field of surgery oxygen is applied routinely over long periods to patients who have had lobectomy or thoracoplasty and is considered of great value.

A recent development, the use of 98% oxygen for the relief of abdominal distension such as occurs after operations and in many toxic cases of pneumonia, has now been made easily available by slight modifications of existing apparatus. This is also of use in collection of gas in certain other locations, notably in subcutaneous emphysema.

As is so often the case when a procedure is introduced which requires elaborate and expensive apparatus, the effective methods of giving oxygen have become much simpler and less expensive as time has gone on. At present oxygen therapy should be available in every well equipped hospital and the general practitioner should be able, when occasion demands it, to apply it in the home. The technique of application is simple and the methods of testing the amount of oxygen which the patient is receiving, a procedure which should always be used with any tent or box method, has been so simplified that it can be carried out routinely by the attending nurse.

If Thomas Beddoes, who founded the Pneumatic Institution at Clifton in 1798 could look down on what is now going on in the medical world, he would feel that again, as in the matter of anaesthesia inhalations, so now in case of oxygen therapy, his labors, the futility of which he once bewailed, had indeed borne fruit.

THE HOSPITAL AND THE COMMUNITY

"American Medicine, Expert Testimony out of Court" contains a great deal of wise and some less wise comment as to desirable and undesirable possibilities in the development of organized medical care. These comments and opinions cover a wide range of subjects, most of which are complicated and some of which cannot be settled at this time. The extracts from letters of physicians, which form the body of the report, are grouped under separate headings, so that one can look up any of the more important aspects of medical care. The medical periodicals have all published reviews of the work, two of the best of these being those in the issue of the *New England Medical Journal* of September 16, and the June number of the *Rhode Island Medical Journal*. Two sets of the original volumes are in the Rhode Island Medical Library.

Among the facts that emerge fairly clearly from all this discussion is this, that our hospital facilities are an essential factor in improved medical care for the great mass of the people. This is true in private practice and would be true in organized care of the indigent and near indigent. Any plans for care of the sick must recognize the importance of the hospital. Here and now, without necessarily any change in the method of financing medical care, it would seem possible to utilize our hospitals to greater advantage in this respect. The hospital could emphasize the consultant and diagnostic clinic function, making a point of returning the patient to his own physician in the shortest possible time.

The practitioner should be able to send his near indigent patient to the hospital, with confidence that the patient would be quickly returned to him with a complete report of the diagnostic methods employed and the conclusions. This would encourage physicians to use the hospital more for their poorer patients, would enable more of these patients to have the benefit of a thorough work up, and would enable the hospitals to use their facilities effectively. The consultation clinic which has been developed by the Providence Tuberculosis League and which is widely used by the doctors of Providence is a fine example of what can be done in this way.

This development of diagnostic work would not necessarily mean any great increase in the number of patients actually in the hospital at any one time. It would not mean at all that more patients should be taken out of private practice. Relatively few of the sick need a hospital work up and those that do, except for the truly indigent, can be returned promptly to their own doctor. Such a plan would undoubtedly strengthen the system of private practice. A pleasant and frequent contact with the hospital should form a very definite part in the life of every physician. The hospital is necessarily a center of medical study and knowledge. He should feel that this is to an extent his hospital, and a definite help to him in his practice.

Not the least important side of this question is the impending increase of government support and control of medical care. It will be most advantageous to all concerned if the integration of hospital care and private practice can be advanced further under the initiative of the medical men before the entrance of other forces into the field confuses the situation.

RHODE ISLAND MEDICAL SOCIETY

Meeting of the Council

A stated meeting of the Council of the Rhode Island Medical Society was held at the Medical Library Building, Thursday, September 16, 1937, at 4:00 P. M. The meeting was called to order by the President, Dr. Walter C. Rocheleau. Present were Drs. Rocheleau, Holt, Wells, Mowry, Jones, Miller, Christie. The minutes of the last meeting of the Council were read by the Secretary and were approved. It was voted that consideration of the budget for 1938 be deferred to the January meeting. The Secretary announced that he had received an application for fellowship by certificate from the New York State Medical Society to the Rhode Island Medical Society. He reported an inquiry from a physician practicing in Block Island as to fellowship in the Society.

Dr. Miller reported that, inasmuch as he had sent to the Committee on Publication his resignation as Editor of the *Rhode Island Medical Journal*, he could speak without personal bias on the condition of the *Journal*. He stated that in his opinion the present arrangement, whereby the Society contributes nothing to the support of the *Journal* but takes any profit that may accrue, is impracticable. He paid a well deserved tribute to Dr. Skelton for his efficient management of the *Journal* during many years. He recommended that the financial management of the *Journal* be vested either in the Publication Committee or the Business Manager. He stated four possible solutions of the problem:—

1. To discontinue publication of the transactions of the Society. After an unbroken record of 78 years this does not seem desirable. The Society would face increased lack of interest, the Library would lose the many exchanges and the books which are reviewed.

2. To arrange with the *New England Journal of Medicine* for publication of the transactions of the Society.

3. To return to the Business Manager control of the *Journal*, financial and otherwise.

4. To entrust financial and editorial control of the *Journal* to the Committee on Publication.

In case the last plan should be adopted, Dr. Miller recommended:—

1. That members of the editorial and business board of the *Journal* be not eligible for membership on the Committee on Publication.

2. That the Business Manager make a monthly report on the condition of the *Journal* to the Publication Committee.

3. That the Publication Committee submit to the Council an annual report on the financial condition of the *Journal.*

4. That the Council appropriate a sum equivalent to the price of one subscription to the *Journal* for each member of the Rhode Island Medical Society.

5. That the mailing list of the *Journal* include the names of each member of the Rhode Island Medical Society, each member of a District Society not a member of the State Society, publishers of journals received by the Medical Library in exchange for the *Rhode Island Medical Journal,* publishers of books received by the Medical Library from Review Editors of the *Journal,* libraries to which the Trustees of the Fiske Fund are accustomed to send copies of the Fiske Fund Essays.

6. That a combined mailing list for members of the Providence Medical Association and the *Journal* be considered.

These matters were discussed and were referred for judgment to the Committee on Publication. The meeting was adjourned at 5:00 P. M.

Respectfully submitted,

GUY W. WELLS, M.D.,
Secretary.

Meeting of the House of Delegates

The regular meeting of the House of Delegates of the Rhode Island Medical Society was called to order at 5 P. M. September 16, 1937, by the President, Dr. Walter C. Rocheleau.

The Secretary then read the report of the meeting of Council which had immediately preceded the meeting of the Delegates. It was moved, seconded and passed that the report be accepted.

Dr. Mowry then explained that changes in the number and the dates of the meetings of the Council and House of Delegates necessitated reporting the annual budget at the January meeting instead of the November, as had been the case in previous years. The House of Delegates approved the change by vote.

As there was no further business to come before the House of Delegates, the meeting adjourned.

Respectfully submitted,

GUY W. WELLS, M. D., *Secretary*

Report of Delegate to the American Medical Association

The Eighty-eighth Annual Session of the American Medical Association was held this year in Atlantic City. The total number of doctors registered was 9,764, almost 10,000.

Each year the size and significance of these meetings seem to increase. The Atlantic City Auditorium is the largest one in this country and its exhibiting space was taxed to capacity. Even the stage was utilized for exhibits. One could not, during the time of the convention, visit all exhibitions with profit though the program was arranged to conserve the members time to the greatest degree. Since the assembling hours of the various sections were staggered and the authors of most of the papers were also exhibitors, one found it comparatively easy to hear all of the papers of particular interest to himself, then to personally discuss the subject with the author in his booth. This plan, adopted last year, seems to have met with great favor. Never before have I seen such a constant shifting of audiences after each paper.

The Sessions of the House of Delegates began June 7 and lasted through June 10. There were several executive sessions.

After reading President Gordon Heyd's splendid address one gets an impression of the controversial subjects that are likely to arise. The fact that many such matters were discussed in a sound and unbiased manner is a great credit to the good judgment of the officers and members of the House of Delegates.

Dr. Heyd called attention to and warned the profession of the dangers of the extension of institutional medicine. Most of these institutions are faced with diminishing financial returns and are willing to accept government aid and later political domination. The possibilities from such institutions are alarming and will require alert, united medical opposition. Dr. Heyd also reviewed other problems which he believes can and should be solved by the profession.

President-elect Upham was chiefly interested in Medical Education and the influence the American Medical Association has exerted on the advancement of medical knowledge. He recommended to state societies consideration of plans whereby postgraduate work could be brought to the doctor. Some states already have in operation such courses. Dr. Upham also urged consideration of some plan to counteract the misinformation given to the public by quacks, cults and patent medicine venders.

The House of Delegates was honored by an address by the Honorable J. Hamilton Lewis of Illinois. Senator Lewis discussed a plan that is not quite clear to me, at least the details. The plan, as I understood it, embraced a scheme to issue Federal licenses to doctors and therefore subject them to governmental control in the matter of treatment of citizens of the State, the reason being that the Federal Government was naturally interested in the individual for economic, military and other reasons. Reduced to its simplest terms, such a plan means State Medicine. It should be emphasized that Senator Lewis apparently is not in sympathy with such a view and came both to warn the medical profession of the danger and to gain from the profession help in formulating a plan acceptable to them. Senator Lewis paid tribute to the service doctors had rendered to the public and also the exacting and expensive preparation incident to medical education. The proponents of the plan, of course, were not named. Senator Lewis further brought a message from the President who wished us success. The President expressed a hope that we might find a way to cooperate with him in a method that would be of service to the helpless and the afflicted within such province as the government might undertake.

Limited space prevents me from reporting more than a few of the interesting matters that came before the House.

At the Kansas City Session a resolution was adapted providing for the appointment of a committee to propose changes in the By-Laws Providing for Fitting Recognition to Fellows Rendering Distinguished Service in Science and Art of Medicine. This committee reported the necessary amendments to the By-Laws and the committee's report was adopted. Hence, it will now be possible for the American Medical Association to honor an outstanding member of the profession in some other manner than by election to an important office.

The Board of Trustees adopted a resolution recommending the establishment of a Council on Industrial Health to permit the Association to assist more efficiently in the prevention and treatment of an increasingly important phase of illness. The resolution was passed by the House of Delegates.

The House of Delegates approved the report recommending the international nomenclature for blood grouping as suggested by the Health Committee of the League of Nations as a standard for the profession. Also, that laws modeled after those of New York and Wisconsin be passed permitting courts to order blood grouping tests in cases of disputed paternity and to receive the results in evidence.

The following officers were elected:

President-Elect, Dr. Irvin Abell; Vice-President, Dr. Junius B. Harris; Secretary, Dr. Olin West; Treasurer, Dr. Herman L. Kretschmer; Speaker of the House of Delegates, Dr. N. B. Van Etten; Vice Speaker of the House of Delegates, Dr. H. H. Shoulders; Trustees, Dr. Arthur W. Booth, Dr. R. L. Sensenich.

San Francisco was chosen for the next Annual Meeting.

Respectfully submitted,

GUY W. WELLS, M.D.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the October Meeting

The regular monthly meeting of the Providence Medical Association was held at the Medical Library, Monday, October 4, 1937, at 8:30 P. M. In the absence of the President, the meeting was called to order by Dr. Alex. M. Burgess. The Secretary read the minutes of the June meeting, which were approved as read. The Secretary read the report of the Standing Committee, approving the applications for membership of the following:

Henry M. Bernhardt
William Fain
Robert Fienberg
Frank Domenic Fratantuono
David Freedman
John E. Menzies
Edwin Basil O'Reilly
John Francis Regan
Vincent Paul Rossignoli
Charles Edwin White

On motion of Dr. Gormly, this report was accepted and the applicants were declared elected as members of the Association.

Dr. DeWolf read the final report of the Committee on Medical Care of the Low Income Group. On motion of Dr. Hughes, amended on motion of Dr. Chafee, this report was accepted and placed on file, the Committee was given a vote of thanks for their work, and the Secretary was instructed to send

a copy of the report to each Rhode Island Senator and Representative in Washington. On Dr. DeWolf's inquiry as to whether the Committee was discharged, the acting President ruled that the Committee was discharged as recommended in its report. Dr. Ruggles then spoke on the importance of the work of this Committee and recommended that the Association continue its interest in medical care of the low income group.

Dr. Streker read the final report of the Committee on Reorganization. On motion of Dr. Gormly, it was voted to accept the report, to refer it to the Standing Committee, and to send a copy to each member of the Association before the next regular meeting. The report was discussed by Drs. Ruggles, Gormly and Streker.

Dr. Seebert J. Goldowski then presented a paper on "Peripheral Arterial Disease." The paper was illustrated with lantern slides.

Dr. William Newton Hughes read "Two Well Known Poems of Neurological Interest." The poems were Kipling's "The Post that Fitted" and "La Nuit Belle." The first illustrates epilepsy and the second, alcoholism.

Dr. Charles Bradley then presented a paper entitled "The General Practitioner and the Feeble-Minded Child." This paper was discussed by Dr. Langdon.

The meeting was then adjourned. Attendance, 94. A collation was served.

Respectfully submitted.

HERMAN A. LAWSON, M.D.,
Secretary.

Final Report of the Committee on Medical Care of the Low Income Group

The Committee on Medical Care of the Low Income Group, Doctors DeWolf, Beardsley, Belliotti, Nestor, Richardson, W. S. Streker, Wells, Jordan, Buffum, and Saklad, appointed on November 4th, 1935, by Dr. William P. Buffum, then President of this Association, offers as its final Report the following:

The investigation proposed for study by this Committee was twofold in nature: First, to determine if, in Providence, any considerable proportion of persons in the Low Income Group suffered hardship through the payment of medical fees. Second, if so, and as a result, was there, in this group, lack of adequate medical care.

As a natural corollary to these problems, should they be answered in the affirmative; ought the Providence Medical Association to take action to relieve the conditions. Two questions immediately presented themselves: First, how define the Low Income Group. Second, how undertake the investigation? The first question, after much discussion and reference to literature upon the subject, was answered thus:

Annual Income, from all sources, below $900 for a family of four persons, was considered too little to warrant paying *any* fees; such families were listed as Clinic cases. Most families, even if large, with income of $1700 or over, were rated as able to pay regular fees. The Low Income Group was classified as follows:

4 in the family $900
to
5 in the family $1100
to
6 in the family $1300
to
7 in the family $1500

The second question, the method of investigation, after discarding several suggested plans, was decided as follows:

Through the co-operation of the Personnel Director or Industrial Nurse in five of our largest local industries, intimate personal questioning was carried out with those of their employees falling in the Low Income Group. The questions asked were based upon a comprehensive questionnaire, prepared by the Committee, in consultation with Professor Carl Doering of Harvard University.

The industrial concerns chosen were: Gorham Manufacturing Co., Brown & Sharpe, Nicholson File, Wanskuck Co., and the U. S. Finishing Co. The interest shown by the executives of these companies was great; the labor of the investigation, undertaken by the Personnel Director and Nurses, was time consuming and, no doubt, exhausting. The Committee here would express to all these individuals its most sincere appreciation and thanks. It was believed and proved to be the fact, that such close, intimate, and friendly contact between employee and intelligent investigator would yield the most accurate and worthwhile records obtainable. This method is conceded by those familiar with such investigations to be the most accurate yet devised. Though the total figures might not be large, your Committee believed they would represent a fairly accurate cross section of like industrial

employees throughout the City. This then was the set up. The results:

1500 employees were interviewed or their incomes investigated.

84 employees fell within the above classification of Low Income Group.

54 of the cases were considered "satisfactory," i.e. to have been well cared for in sickness for which they paid medical fees without undue hardship.

17 cases had no sickness during 1934-35, the years covered by the questionnaire.

2 did not receive proper care, probably through their own neglect.

2 used the free clinic too much, and should have employed a doctor.

3 paid too little or not at all.

6 paid too much, two of these being doubtful cases, in which all the circumstances could not be known.

Several interesting facts were developed as the answers to the questionnaires were studied.

First, Average charge for Home Visits $2.53
Average charge for Office Visits $1.90

Your Committee was impressed by the moderate charges to these people of the Low Income Group. It was evident that the time immemorial habit of the medical profession in adjusting medical charges to the patients' ability to pay was almost universally followed in these cases. In two instances there would appear to be overcharging, but in these all the circumstances were not known.

Second, in several cases, what has been called "Catastrophic Illness" occurred, as for instance, sickness, confinement, and operation in one year. Almost without exception, in these cases, payment was made, up to the family's ability, and then recourse was had to the clinic or hospital for free treatment.

Conclusion: It is recognized by your Committee that the number of cases in this group is small, but as stated above, it is probably accurate and represents fairly well a cross section of the Low Income Group in Providence. It is felt that could an equally correct, but much broader study be made, which would take time and money, the results would, no doubt, be better. Such a plan is, at present, vaguely outlined by one of our Social Agencies and should it materialize, will be reported to this Association.

It is clearly recognized by your Committee that its investigation is in no wise a solution of the ever present problem of the cost of medical care to the Low Income Group and that all further efforts to solve this problem should receive our earnest support.

Finally, in view of the findings, as outlined above, i.e., 1,500 cases considered, 84 falling within the Low Income Group, 6 having paid too much for medical care, and further, in the belief that with the fine equipment of this City in the way of Hospitals, City and District Nurses, free Clinics, etc., the great majority of those in the Low Income Group are adequately cared for without undue financial strain to themselves, and again, being confident that no formal plan or action on the part of this Association can actually bring relief to those few who may be sufferers from the expense of sickness.

Your Committee recommends that no such action be taken.

The Committee also asks that it now be discharged.

Respectfully,
HALSEY DEWOLF, M.D.,
Chairman.

Report of the Committee on Reorganization

Oct. 4, 1937.

To the members of the Providence Medical Association:

At the January meeting of this year it was suggested to the Providence Medical Association that this society should take a more active part in the development and control of medical practice in the community, including the various health agencies, clinics, industrial medicine, and medical legislation; also that it should exercise a greater influence in attempts to solve present day medico-economic problems. It was further suggested that some changes in our organization be considered in order to carry out the above, and this committee was appointed to study the question.

Having arrived at definite conclusions, the committee submitted a preliminary report at the June meeting. This was done in order to give the members ample opportunity for personal deliberation. This report stated that the committee had decided to make two specific recommendations:

I. That the Standing Committee be enlarged to afford more complete representation in this committee which initiates practically all of the business of the association and also acts as the nominating committee.

II. That the association employ an executive secretary. This proposal is in keeping with present day trends in many progressive county and state medical societies. Considerable correspondence has been held regarding this question, with the A.M.A. and several county medical societies who employ executive secretaries. A recent exhaustive study was furnished by the A.M.A. Opinions and comments were overwhelmingly favorable to the idea of employment of an executive secretary.

An executive secretary would work with and under the direction of the Standing Committee, act as secretary to the various other committees, thereby correlating all of the society's activities. The indications are that under this plan the activities of the society would increase and become more efficient and effective. The association would keep in touch with the various health agencies which have progressed to wide development with little or no organized medical supervision or direction. Medico-economic problems and matters concerning public relations require more executive activity than the elective officers can be expected to perform. It is felt that these and other related services would increase considerably the value of this society to its members.

We therefore, in this the final report of the committee, recommend the following changes in the by-laws:

Article I. Sec. 1. That the words "consisting of five members" be deleted.

Article I. Sec. 6: That the first paragraph be changed to read as follows: The Standing Committee shall consist of the President, Vice-President, Secretary, and Treasurer, *ex-officio*, and of ten members, and after the adoption of this amendment the present membership shall be added to as follows:

two members shall be elected for a term of five years,
one member for a term of four years,
one member for a term of three years,
one member for a term of two years,
one member for a term of one year,

and thereafter two members each year for a term of five years.

Article I. Sec. 6. Be amended to read at the end of paragraph three: The Standing Committee shall be authorized to employ an executive secretary, to outline his duties and to fix his salary and expenses of office within the appropriation voted by the association for the purpose.

Respectfully submitted,

Wm. S. Streker, M.D., *Chairman*
Peter P. Chase, M.D.
Frank B. Cutts, M.D.
Wm. P. Buffum, M.D.
Harry C. Messinger, M.D.
Wm. A. Horan, M.D.
Frederic J. Burns, M. D.
Executive Secretary to the Committee

Rhode Island Hospital

SCHEDULE FOR NOVEMBER, 1937

Thursday, November 4
Gyn. Staff Meeting ..... 8.30 P. M.
Friday, November 5
G. U. Staff Meeting ..... 7.30 P. M.
Surgical Staff Meeting ..... 8.30 P. M.
Wednesday, November 10
Annual Meeting ..... 12.00 noon
Tuesdays, November 9 and 23
Clinical-Pathologic Conference ..... 12.00 noon
Mondays
Surgical Grand Rounds ..... 10.00 A. M.
I. November 8 and 22
II. November 1, 15 and 29
Thoracic Clinic ..... 4.30 P. M.
Tuesdays
Gastro-Intestinal Clinic ..... 9.30 A. M.
Surgical Grand Rounds ..... 10.00 A. M.
I. November 1, 15 and 29
II. November 9 and 23
Wednesdays
Tumor Clinic ..... 10.00 A. M.
Skin Clinic ..... 12.00 noon
Thursdays
Orthopedic Grand Rounds ..... 9.00 A. M.
Thoracic Clinic ..... 11.30 A. M.
November 11—Armistice Day
Fridays
Fracture Grand Rounds ..... 11.00 A. M.
Heart Conference ..... 11.30 A. M.
Saturdays
Neurological Grand Rounds ..... 9.00 A. M.
Medical Conference ..... 10.00 A. M.

On October 1st, Dr. Daniel M. Swan, of Watertown, N. Y., left for his home, having served as Intern at the Rhode Island Hospital for two years. Dr. Swan is a graduate of Colgate University and

the University of Rochester Medical School. Dr. Swan contemplates entering Peter Bent Brigham Hospital on January 1, 1938, having received a year's appointment in Medicine in that institution.

Dr. Ralph Richardson, who substituted in an administrative capacity during the past Summer, on October 1st entered the Memorial Hospital in Boston, having accepted a Pathological internship for a year.

Dr. David P. Dutton, a graduate of Harvard University Medical School in 1937, started his internship on October 15th. Dr. Dutton's home is in Wakefield, Mass.

Dr. Charles Chesner started a Pathological internship on October 15th.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held September 13, 1937, with Dr. T. Frank Kennedy presiding. Dr. Thomas J. Lalor was the main speaker of the day. He read a paper entitled "Arthritis, Atrophic and Hypertrophic." This was very well received and was followed by considerable discussion in which several of the members participated.

On September 27, the Monthly Clinical Conference was held. The Medical Records Committee offered a report stressing the importance of complete records. A general discussion followed. During the latter half of the period, Dr. Rocheleau presented a case of "Petit Mal".

At a recent meeting of the Board of Trustees of the Woonsocket Hospital, Dr. Walter C. Rocheleau, President of the Rhode Island Medical Society, was elected a member of this Board.

NEW ENGLAND SURGICAL SOCIETY

The meeting of the New England Surgical Society was held in Providence, October 1 and 2, with headquarters at the Biltmore Hotel. Attendance was over 100. Friday, October 1, operative clinics were held from 8:00 to 10:00 A. M.; at the Rhode Island Hospital by Drs. Kingman, J. C. O'Connell, Stone, Waterman, Pitts, McCabe, Messinger, C. O. Cooke and Kerney; at the Memorial Hospital by Drs. Hussey, Holt and Shaw. At the Peters House Auditorium of the Rhode Island Hospital, the following demonstrations were given:

The Surgical Treatment of Hare-Lip and Cleft Palate by Dr. Albert A. Barrows

Presentation of Thoracic Clinic Patients by Dr. Halsey DeWolf and associates

Presentation of a Group of Tumor Clinic Patients by Dr. B. Earl Clarke and associates

Presentation of Fracture and Orthopedic Patients by Drs. Murray S. Danforth, Peter P. Chase, Herbert E. Harris, and Henry F. McCusker

The Use of 95% Oxygen in the Treatment of Abdominal Distension by Dr. Alex. M. Burgess

Posture in Anesthesia by Dr. Albert H. Miller

Summary of End Results in the Treatment of Carcinoma of the Cervix by Dr. George W. Waterman

At the Memorial Hospital the following demonstrations were given:—

Internal Fixation of Hip Fractures by Dr. Herbert E. Harris

Surgical Risks from the Medical Standpoint by Dr. John F. Kenney

Surgical Risks from the Standpoint of the Anesthetist by Dr. Meyer Saklad

X-Ray Aids in Surgery by Dr. Emanuel W. Benjamin

Two Problem Cases: 1. Acute Obstruction Due to Cancer of Sigmoid and Transverse Colon—Operation—Complications. 2. Congenital Retro-vaginal Fistula in a Child 7 years of age—Operation by Dr. Arthur T. Jones

Case Report: Pyloric Stenosis, primary Ramstedt operation, secondary posterior gastro-enterostomy. Motion pictures of Common Duct Stone. Slides showing Injection of Common Duct by Dr. Frederic V. Hussey

Case Reports: Operation and After-Treatment of Thoracoplasties by Dr. Eliot A. Shaw

Case Reports: 1. Abdominal Pregnancy. 2. Compound Fracture of the Skull caused by bursting emery wheel by Dr. Charles H. Holt

At 1:00 P. M. luncheon was served at the Rhode Island Hospital.

Friday afternoon the following scientific program was presented at the Nurses' Auditorium of the Rhode Island Hospital:—

A Series of Atypical Osteotomies for Deformity by Dr. Frederic J. Cotton. *Discussion:* Dr. Ezra A. Jones, Dr. Frank R. Ober

Sub-periosteal Resection of the Manubrium for Funnel Chest by Dr. Philemon E. Truesdale. *Discussion:* Dr. James W. Sever, Dr. Frederic J. Cotton

Immediate Surgery in Acute Cholecystitis by Dr.

Howard M. Clute. *Discussion:* Dr. Carl M. Robinson, Dr. Frank H. Lahey

Acute Haemorrhagic Pancreatitis by Dr. George Dunlop—by invitation. *Discussion:* Dr. Ernest L. Hunt, Dr. Irving Walker, Dr. Lium

The Surgical Treatment of Abdominal Fistulae by Dr. Samuel F. Marshall—by invitation. *Discussion:* Dr. Frank H. Lahey, Dr. H. Gildersleeve Jarvis

Intestinal Tuberculosis by Dr. George A. Moore *Discussion:* Dr. James W. Jameson

At 5:00 P. M. the meeting adjourned to the Squantum Club where a Rhode Island Clam-bake was served.

Saturday morning, the following program was presented at the Rhode Island Medical Library Auditorium:—

The Operative Treatment of Ulcerative Colitis by Dr. Charles C. Lund. *Discussion:* Dr. Richard B. Cattell, Dr. Leland S. McKittrick

Carcinoma of the Colon by Dr. Donald S. Adams. *Discussion:* Dr. Edward L. Young, Jr., Dr. Charles L. Larkin, Dr. Arthur W. Allen, Dr. Frank H. Lahey

The Relief of Pain in Malignant Disease by Dr. John S. Hodgson. *Discussion:* Dr. Ernest M. Daland, Dr. James C. White

An Unusual Case of Intestinal Obstruction by Dr. Daniel C. Patterson. *Discussion:* Dr. Robert C. Cochrane, Dr. Donald B. Wells

Reconstruction Operations for Hypertrophy of the Female Breast by Dr. Horace K. Sowles. *Discussion:* Dr. George C. Wilkins, Dr. Frank A. Pemberton

At the executive session, the following were elected members of the Society:—

Edward H. Kirschbaum	Waterbury, Conn.
George F. Dwinell	Manchester, N. H.
Peter P. Chase	Providence, R. I.
George W. Waterman	Providence, R. I.
Philip H. Wheeler	Brattleboro, Vt.
Herbert A. Durfee	Burlington, Vt.
Charles H. Jameson	Camden, Maine
Stephen A. Cobb	Sanford, Maine
George A. Tibbetts	Portland, Maine
Gilbert Horrax	Brookline, Mass.
Harlan F. Newton	Brookline, Mass.
Grantley W. Taylor	Boston, Mass.
Bancroft C. Wheeler	Worcester, Mass.
Marius N. Smith-Petersen	Newton, Mass.
Fletcher H. Colby	Boston, Mass.
John Rock	Brookline, Mass.
Horatio Rogers	Newton Centre, Mass.
Charles L. Curtis	Salem, Mass.
Carl H. Stevens	Belfast, Maine

Dr. John M. Birnie, of Springfield, was elected President and Dr. John F. Gile, of Hanover, Secretary.

The ladies who attended were entertained on Friday morning by Mrs. Murray H. Danforth with a tour of inspection of the new Rhode Island School of Design and the Carrington mansion, followed by a luncheon at the Rhode Island Country Club. In the afternoon they took the ten-mile drive in Newport. They were entertained at dinner by Mrs. Herman C. Pitts and Miss C. Amey Kingman.

PERSONAL NOTES

October 13.

At the meeting of St. Joseph's Hospital Staff Association, held at the Nurses' Auditorium at 8:45 P. M., Dr. Charles A. McDonald spoke on "Brain Pathology with Clinical Histories." Collation was served.

Drs. William B. Cohen, F. Ronchese, and Vincent J. Ryan attended the first quarterly meeting of the New England Dermatological Society, held at the New Haven Hospital.

October 15.

Initiating the fiftieth season of the activity of the Friday Night Medical Club of Providence, Dr. Dennet L. Richardson read a paper on "Prontylin." He reported the results of treatment with sulfanilamide at the Charles V. Chapin Hospital in 155 cases of streptococcus infection. The paper was discussed by Dr. Kalei K. Gregory, Dr. Edmund G. E. Anderson, and members of the Club.

October 19.

The regular monthly meeting of the General Staff of the Homeopathic Hospital of Rhode Island was held at the hospital at 12:30 P. M. Dr. W. Richard Ohler of Boston spoke on "Certain Aspects of the Relationship of Vitamin Deficiency to General Practice."

The Annual Meeting and Dinner of the Rhode Island Record Librarians' Association was held at the Narragansett Hotel on Tuesday evening, October 19, 1937, at five o'clock.

Following the dinner, the regular business meeting of the Association was called to order by Miss M. Irene Cavanaugh, President. Officers for the coming year were elected: Miss Elizabeth M. Bingham, President; Miss Sarah Litwin, Vice President, and Miss Mary Nunez, Secretary-Treasurer.

Mrs. Ellison Creighton Frazier, Record Librarian of the Rhode Island Hospital, who has retired, was presented with a farewell gift from the members of the Association.

After a round table discussion, the meeting was adjourned at 8:00 P. M.

October 22

At the meeting of the Providence Medical History Club, Dr. John E. Donley read a paper on "Benjamin Rush."

October 26

The Amos Throop Medical Club was entertained by Dr. George L. Shattuck. Dr. Walter C. H. Weigner read a paper on "Functional Factors in Disease."

Drs. Eliot A. Shaw and Charles J. Ashworth returned from a two weeks visit to surgical clinics at St. Louis and the Mayo Clinic at Rochester.

October 28

At the Regular Quarterly Meeting of the Rhode Island Medico-Legal Society, held at the Medical Library at 5:00 P. M., Dr. James Philip Deery, Chief of the Division of Industrial Hygiene, Rhode Island Department of Public Health, read a paper on "Industrial Hygiene and its Effect on Compensation."

RHODE ISLAND MEDICAL SOCIETY

The Library Committee gratefully acknowledges a gift to the Davenport Collection from Dr. G. Alder Blumer:—"Exercitationes de Generatione Animalium." By William Harvey, Amsterdam, 1651.

RECENT BOOKS

SURGICAL PATHOLOGY OF THE THYROID GLAND. By Arthur E. Hertzler, M.D., pp. 298 with 238 illustrations. Cloth, $5.00. J. B. Lippincott Company, Philadelphia, 1936.

This is a most interesting book on thyroid disease, probably more suited for those who are especially interested in this subject. It is not written in the manner of the usual text-book but as the author states, an attempt to record his observation of the disease based upon a long clinical experience. He stresses our lack of knowledge relative to the histology and physiology of the gland and the need for further study of the problem. On many points he does not appear to be in accord with the prevailing views upon the subject. He believes that the so-called non-toxic goitre and degenerative goitres are productive of cardiac changes leading to failure and holds that their removal is as important as the removal of the hyperplastic types that produce obvious clinical signs. Recognition and treatment of fetal adenoma of the thyroid by removal is urgently advised because of the high percentage of malignancies originating in these congenital tumors. His explanation of "benign metastasizing' goitre is that the malignant ademona is overlooked among surrounding adenomatous formation. The book is recommended to those interested in this subject.

JAMES H. FAGAN, M.D.

EMOTIONAL ADJUSTMENT IN MARRIAGE. By Le Mon Clark, M.S., M.D., Assistant in Obstetrics and Gynecology, University of Illinois College of Medicine. pp. 261, Cloth, $3.00, The C. V. Mosby Co., St. Louis, 1937.

Under this title, Dr. Clark presents a dignified, scientific discussion of the topics comprised in the popular mind under the heading "Sex." The work is addressed to normal young people of the marrying age; it considers no sexual abnormality. To those who hold that sexual matters should be left to the teaching of harsh experience, the author replies: "By veiled suggestion, by innuendo, by downright falsehood and misrepresentation, by anything and everything but by 'leaving them to nature' we have completely altered this otherwise natural response." Unequivocally condemning induced abortion, he deals reasonably with the problem of birth control, showing by arithmetical calculation that some natural or artificial form of birth control must sooner or later supervene to prevent hopeless overcrowding.

This book is to be recommended to the married and those who contemplate marriage and to parents, physicians and teachers who through ignorance or diffidence are unable to give the instruction on sexual matters which the present enlightened state of civilization demands.

AN INTRODUCTION TO DERMATOLOGY. By Richard L. Sutton, M.D., Sc.D., LL.D., F.R.S. (Edin) and Richard L. Sutton, Jr., A.M., M.D., L.R.C.P. (Edin). Third Edition, pp. 666, with many illustrations. Cloth, $5.00. The C. V Mosby Company, St. Louis, 1937.

This book is not merely a compilation of the work of others as the authors do not hesitate to express their own opinions. Special emphasis is laid on the importance of accertaining the cause, if possible, before instituting treatment, and reliance on purely symptomatic measures is confined to diseases of obscure or unknown etiology.

To facilitate the diagnosis of tuberculous lesions, the authors have used a modification of the classification of Gans. Considerable attention is given to the parasitic affections. Over 100 pages containing many beautiful photographs are devoted to plant and animal parasites capable of producing disease in man. It is particularly interesting to note the emphasis placed on bismuth in the treatment of latent syphilis. Although the book is intended primarily for students, I feel certain it will meet with the approval of all practitioners of medicine.

VINCENT J. RYAN, M.D.

THE LABORATORY DIAGNOSIS OF SYPHILIS, THE THEORY, TECHNIC, AND CLINICAL INTERPRETATION OF THE WASSERMANN AND FLOCCULATION TESTS WITH SERUM AND SPINAL FLUID. By Harry Eagle, M.D., with Foreword by J. Earle Moore, M.D., pp. 440, with 27 illustrations. Cloth, $5.00. The C. V. Mosby Company, St. Louis, 1937.

This timely book discusses the laboratory diagnosis of syphilis in a comprehensive and readable way. The time honored Wassermann test and the newer flocculation tests are critically reviewed. The larger portion of the book is perhaps mostly of interest to physicians and technicians actually engaged in the laboratory diagnosis of syphilis. Details of technic, sources of error and how to avoid them, relative merits of various technics and the standardization of technics are all clearly and helpfully discussed.

The section on "The Clinical Evaluation of the Serologic Report", should be of more general interest. The twenty pages devoted to theories of the nature of the reactions may seem abstract to some but the following chapters, and particularly that on the interpretation of doubtful reports, should be helpful to all clinicians. In this connection he deplores the common practice of reporting 1+, 2+, 3+ and 4+ and makes a plea for making all reports either negative, positive or doubtful. This should meet with universal approval.

This book should be in the working library of every clinical laboratory.

B. EARL CLARKE, M.D.

YOUR DIET AND YOUR HEALTH. By Morris Fishbein, M.D. Cloth, pp. 298, $2.50, McGraw-Hill Book Company, Inc., New York, 1937.

Mindful of the confusion that is prevalent among the laity regarding diet and nutrition, the author attempts to clear the minds of those who are anxious to learn the truth. The subject has suffered considerable abuse from charlatans, quacks, and food faddists. "Your Diet and Your Health" is therefore timely. This monograph is divided into 26 chapters and an appendix which consists of a considerable number of tables showing the carbohydrate, protein and fat contents of the various foods and their caloric value. The opening chapter deals with discussion of the calorie, what is meant by the term calorie and the variation in caloric needs of different individuals. This is followed by a brief but quite adequate resumé of the physiology of digestion and its relation to good health.

In the chapters that follow he humorously and in spots quiet severely criticizes the various diet systems, and backed by scientific evidence, tells us how absurd and unscientific their claims are. The much talked of and quite frequently abused vitamins are also taken up step by step, their real importance explained and source of supply in nature indicated. There are special chapters on diets in disease conditions, on food sensitivities and other special diets. The material is well organized, vigorously and smoothly written and easily digestible.

LOUIS I. KRAMER, M.D.

SYPHILIS, THE NEXT GREAT PLAGUE TO GO. By Morris Fishbein, M.D., Editor, Journal of the American Medical Association and of Hygeia, the Health Magazine. Cloth, $1.00, David McKay Co., Philadelphia, 1937.

In this handbook of seventy pages, with many graphic charts and well chosen illustrations, Dr. Fishbein describes in simple terms this great plague, its reason for being and the measures to be taken for its eradication. For this scourge can be eradicated and it will be if the knowledge contained in this book is thoroughly broadcast and absorbed. This is a text which can contribute tremendously to human welfare and happiness. Because the subject is one which may any day become of personal interest to each of us, the heading on the jacket of the book is well justified: "A Handbook for Every One."

SENILE CATARACT, METHODS OF OPERATING. Third Revised Edition. By W. A. Fisher, M.D., F.A.C.S., pp. 150 with 181 illustrations. Cloth, ... The H. G. Adair Printing Company, Chicago, 1937.

The first chapter in this book was written by the late Ernst Fuchs and describes the operation for removal of the lens as he did it, a method which has become practically the standard in this country. There are chapters by Barraquer, Van Lint and Holland of India describing the Col. Smith or Indian intracapsular method very exactly. The preparation of the patient and minute details of operative technique and after-care are thoroughly covered. There is good meaty material in every chapter. The illustrations are for the most part simple diagrams which thoroughly illumine the text. Every oculist should own this book and read it.

HARRY C. MESSINGER, M.D.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933 of RHODE ISLAND MEDICAL JOURNAL published MONTHLY at Providence, Rhode Island for OCTOBER, 1937

State of **RHODE ISLAND**
County of **PROVIDENCE**

Before me, a **NOTARY PUBLIC** in and for the State and county aforesaid, personally appeared **CREIGHTON W. SKELTON, M.D.**, who, having been duly sworn according to law, deposes and says that he is the **BUSINESS MANAGER** of the **RHODE ISLAND MEDICAL JOURNAL** and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management, etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, to wit:

1. That the names and addresses of the publisher, editor, and business manager are: Publisher, **RHODE ISLAND MEDICAL SOCIETY**, 106 **FRANCIS ST.**; Editor, **ALBERT H. MILLER, M.D.**, 28 Everett Ave.; Business Manager, **CREIGHTON W. SKELTON, M.D.**, 106 **FRANCIS ST.**; all of Providence, R. I.

2. That the owner is **THE RHODE ISLAND MEDICAL SOCIETY.**

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are none.

CREIGHTON W. SKELTON, M.D.

Sworn to and subscribed before me this first day of October, 1937.

THOMAS RUSH, Notary Public
(My commission expires June 30th, 1941)